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| | 155377 | A. BUILDING 00<br>B. WING | 05/25/2012 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: May 21, 22, 23, 24, and 25, 2012<br><br>Facility number: 000272<br>Provider number: 155377<br>AIM number: 100274710<br><br>Survey team:<br>Jill Ross, RN-TC<br>Janie Faulkner, RN (May 21, 22, and 23, 2012)<br>Diana Sidell, RN<br>Cheryl Fielden, RN<br><br>Census bed type:<br>SNF/NF: 73<br>Total: 73<br><br>Census payor type:<br>Medicare: 7<br>Medicaid: 61<br>Other: 5<br>Total: 73<br><br>Sample: 15<br>Supplemental sample: 2<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC | F0000 | **PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a DESK REVIEW of compliance for this plan of correction.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | 16.2.<br><br>Quality review completed 6/4/12 by Jennie Bartelt, RN. | | | |

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| F0279 SS=E | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on record review and interview, the facility failed to ensure care plans were developed to meet the residents' individual needs and goals, in that the plans failed to establish approaches that corresponded to the residents' identified problems. The deficient practice affected 3 of 14 residents reviewed for care plans in a sample of 15 (Residents #20, #38, and #52). The deficient practice also affected 1 of 2 residents reviewed for care plans in a supplemental sample of 2 (Resident #34). | F0279 | **F-279 COMPREHENSIVE CARE PLANS**<br><br>A. **ACTIONS TAKEN**:<br><br>1. Resident #20,38,52 and 34 care plans reviewed and approaches revised to ensure that they correspond to the residents identified problems. | 06/24/2012 |

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| | Findings include:<br><br>1. The clinical record for Resident #20 was reviewed on 5/21/12 at 1:37 p.m.<br><br>In the care plan section of the record, each of the resident's care plans had columns titled: problem, goal, approach, and discipline. Each of the resident's identified problems was listed on a separate care plan and included information related to providing care for that problem.<br><br>Resident #20's care plans indicated:<br><br>Problem: "Resident has Dx (diagnosis): Vitamin B 12 deficiency," with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds [medication] as ordered, Notify MD (doctor) and family of any status changes and PRN (as needed)"<br><br>The same information was listed on care plans with problems, based on the resident's diagnoses, as follows.<br><br>"Resident has Dx: Obesity" with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN." | | B. **OTHERS IDENTIFIED**:<br><br>1. All other residents have the potential to be affected.<br><br>2. 100% audit of all residents care plans to ensure that approaches indicated correspond to identified problems to be completed by IDT team by 6/24/12.<br><br>C. **MEASURES TAKEN**:<br><br>1. All Licensed Staff were<br><br>in-serviced on Care Plan development and revision in regards to establishing approaches that correspond to the residents' identified problems by DNS/ designee on 6/12/12.<br><br>2. The IDT will review/revise resident care plans after quarterly assessment, and prn, and during the care plan conference with the resident/ family to ensure that care plans are individualized and meet individual needs and goals. This will be an on-going QA program.<br><br>3. The DON/Designee will review/revise resident care plans | |

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| | "Resident has Dx: Ventral Hernias x 2 3 cm (centimeters)" with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Zinc deficiency" with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Mental Retardation" with a start date of 4/17/12 and a goal target date of 7/17/12, "Resident has Dx: Hypothyroidism" with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Hyperlipidemia" with a start date of 4/25/12 and a goal target date of 7/25/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Moderate Psychosis" with a start date of 4/17/12 and a goal target date of 7/17/12. Approaches indicated, "Labs as ordered, Meds as | | with new orders and change of condition.<br><br>D. **HOW MONITORED**:<br><br>1. To ensure compliance, the DNS/ Designee is responsible for the completion of the Care Plan Updating CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.<br><br>E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:**<br><br>**6/24/12.** | |

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| | ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Major Depression with Psychosis" with a start date of 4/17/12 and a goal target date of 7/17/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: Abdominal Pain" with a start date of 4/17/12 and a goal target date of 7/17/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>"Resident has Dx: HTN" (high blood pressure) with a start date of 4/17/12 and a goal target date of 7/17/12. Approaches indicated, "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>2. The clinical record was reviewed for Resident #38 for care plans on 5/22/12 at 9:30 a.m.<br><br>In the care plan section of the record, each of the resident's care plans had columns titled: problem, goal, approach, and discipline. Each of the resident's identified problems was listed on a separate care plan and included | | | |

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| | information related to providing care for that problem.<br><br>Resident #38's care plans indicated:<br><br>Problems:<br><br>"Resident has diagnosis of Vitamin B 1 deficiency" with a date of 3/15/11 and a goal target date of 6/7/12;<br><br>"Resident has Dx: Nausea and vomiting" with a date of 3/15/11 and a goal target date of 6/7/12;<br><br>"Resident has Dx: Tremors"with a start date of 2/10/12 and a goal target date of 6/7/12;<br><br>"Resident has Dx: Osteoporosis" with a start date of 11/11/2011 and a goal target date of 6/7/12;<br><br>"Resident has Dx: CHF" (congestive heart failure) with a start date of 11/14/11 and a goal target date of 6/7/12;<br><br>"Resident has Dx: History of DVT (blood clot) dated 3/15/11 with a goal target date of 6/7/12;<br><br>"Resident has Dx: History of acute respiratory failure with a date of 4/6/11 and a goal target date of 12/29/12. | | | |

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| | Approaches for each of care plans above were: "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN."<br><br>The review of Pressure Wound Skin Evaluation Report for Resident #38, received on 5/24/12 at 9:03 a.m., from the Corporate Nurse, indicated this resident had a stage IV (4) wound on 12/1/11, and the plan did not indicate it healed until 5/4/12. The care plan with a start date of 12/28/10 indicated there was a "Problem: potential for skin breakdown" but did not indicate this resident actually had an open, stageable wound. No changes or additions to this care plan for skin breakdown were made the Approaches to care. No other care plans for this resident addressed wounds of any kind.<br><br>3. The clinical record for Resident #52 was reviewed on 5/23/12 at 10:20 a.m.<br><br>In the care plan section of the record, each of the resident's care plans had columns titled: problem, goal, approach, and discipline. Each of the resident's identified problems was listed on a separate care plan and included information related to providing care for that problem. | | | |

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| | The care plans Problems were as follows:<br><br>"Resident has Dx: Aspiration Pneumonia" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: Contracture to left hand" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: Old right CVA" (stroke) with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of hypothermia" (low body temperature) with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of Myxedema" (low level of thyroid hormone in the bloodstream) with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of pneumonia" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of Respiratory Failure" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of Metabolic Acidosis" with a start date of 3/21/12 and | | | |

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| | a goal target date of 6/21/12;<br><br>"Resident has Dx: History of Recent septic shock" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: hypothyroidism" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: Cervical stenosis with myelopathy" with a start date of 3/21/12 and a goal target date of 6/21/12;<br><br>"Resident has Dx: History of encephalopathy" with a start date of 3/20/12 and a goal target date of 6/20/12;<br><br>"Resident has Dx: Protein Malnutrition" with a start date of 3/21/12 and a goal target date of 6/21/12.<br><br>Approaches for each of the above problems were: "Labs as ordered, Meds as ordered, Notify MD and family of any status changes and PRN." There were no other approaches made on this care plan for these problems."<br><br>4. The clinical record for Resident #34 was reviewed on 5/23/12 at 9:08 a.m.<br><br>The care plan, dated 11/10/11, was as follows: | | | |

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| | Problems: "Sad mood indicators noted less that daily as evidence by Feeling hopeless, Little energy, Feeling hopeless due to lack of family support/restlessness Secondary to Dx: Mood disorder, Personality Disorder, Depression" with a start date of 11/10/11 and a goal target date of 7/18/12. Approaches: "Enjoys being around others, TV, music, outdoors, Bingo and social events." The care plan did not address any change in the resident's preferences. A plan of care update was made on 4/18/2012, but no changes were made according to the care plan.<br><br>In interview with Resident #34 on 5/22/12 at 3:45 p.m., she indicated she does not participate in activities any more. The resident stated she "quit because they (the activities) were boring." She also indicated no one had done anything to help or change the activities.<br><br>In interview on 5/24/12 at 2:30 p.m., with the DNS (Director of Nursing Services), she indicated she knew there was a problem with the care plans and they (DNS and Corporate Nurse) would work on them.<br><br>On 5/23/12 at 2:00 p.m., the request was made for the policy and procedure on | | | |

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| | implementing care plans. On 5/25/12 at 8:30 a.m., another copy was requested. A policy was received on 5/25/12 at 12:38 p.m., from the DNS and was titled "Care Plan Guidelines." Review of the policy indicated a guide for care plan meetings with families and residents. It did not give guidelines for developing and implementing care plans. No other policy and procedure was provided for care plans. The DNS stated, "This is all we have."<br><br>3.1-35(a)<br>3.1-35(b)(1) | | | |

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| F0334<br>SS=D | 483.25(n)<br>INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; | | | |

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| | (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:<br>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br>Based on record review and interview, the facility failed to give the pneumonia vaccine. This affected 1 of 2 residents reviewed for pneumococcal immunizations in a supplemental sample of 2. (Resident #34)<br><br>Findings include:<br><br>The clinical record for Resident #34 was reviewed on 5/23/12 at 9:08 a.m.<br><br>The MDS (Minimum Data Set) assessment, dated 11/20/11, indicated 00300 was marked as pneumococcal | F0334 | **F-334 Influenza and pneumococcal immunizations**<br><br>A. **ACTIONS TAKEN**:<br><br>1. Resident #34 was given the pneumonia vaccine on 5/24/12.<br><br>B. **OTHERS IDENTIFIED**: | 06/24/2012 |

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| | vaccine offered and declined.<br><br>The signature page for the pneumococcal immunization, dated 10/20/11, had the resident's signature which gave permission for the facility to administer the Pneumococcal Vaccination.<br><br>In interview on 5/24/12 at 8:45 a.m., the Corporate Nurse indicated, "The resident had declined the pneumonia vaccine in 2009. We didn't see the informed consent form signed 10/20/11. We tried to look on the MARS (medication administration records) and TARS (treatment administration records) and can't find where it was given. We are going to give it now."<br><br>The Resident Immunization and Health History Form and the TAR received 5/25/12 at 9:45 a.m., from the Director of Nursing Services, had a date of 5/24/12 for the pneumonia vaccine given.<br><br>3.1-13(a) | | 1. All other residents have the potential to be affected.<br><br>2. 100% audit of all residents pneumonia vaccination consent form to be completed by IDT team by 6/24/12.<br><br>C. **MEASURES TAKEN**:<br><br>1. All Licensed Staff were<br><br>in-serviced on the facility pneumococcal policy and procedure and provision of the pneumonia vaccine according to pneumonia vaccination consent form by the DNS/ designee on 6/12/12.<br><br>2. The IDT will review new admissions for completion of the pneumonia vaccination consent form and to ensure vaccination is administered.<br><br>D. **HOW MONITORED**:<br><br>1. To ensure compliance, the DNS/ Designee is responsible for the completion of the Pneumonia Vaccination CQI tool weekly times 4 | |

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| | | | weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.<br><br>E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is:**<br><br>**6/24/12.** | |

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| F0441<br>SS=D | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>A. Based on record review and interview, the facility failed to ensure PPD/TB | F0441 | **F-441 Resident Records- complete/ accurate/ accessible** | 06/24/2012 |

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| | (tuberculosis) testing was performed in a timely manner, in that Resident #19 received one step of the two step PPD/TB test, and Resident #47 received the PPD/TB test late. This affected 2 of 15 residents reviewed related to screening for tuberculosis in a sample of 15. (Resident #19 and #47)<br><br>B. Based on observation, record review, and interview, the facility failed to ensure a dressing change was provided using standard precautions for sanitizing scissors and handwashing/glove use. The deficient practice affected 1 of 2 residents in a supplemental sample of 2 during 1 of 3 wound care observations. (Resident #40)<br><br>Findings included:<br><br>A.1 Resident #19's record was reviewed on 5/21/12 at 10:30 a.m. The record indicated Resident #19 was admitted with diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease and left hemiparesis.<br><br>Admission to the facility was on 6/17/11. The resident received the first step PPD/TB test on 6/17/11. No other notations regarding the second step PPD/TB test were found in the record. | | A. **ACTIONS TAKEN**: 1. Resident #19 has received a new PPD/TB test cycle. Resident #47 not action required. 2. All licensed staff were in-serviced on wound care policy re standard precautions, glove use, and proper sanitizing of scissors on 6/12/12. B. **OTHERS IDENTIFIED**: 1. All other residents have the potential to be affected by the alleged deficient practice. 2. All licensed staff were in-serviced on wound care policy re standard precautions, glove use, and proper sanitizing of scissors on 6/12/12. 3. 100% audit of all residents PPD/TB test completion by IDT team by 6/24/12. C. **MEASURES TAKEN**: 1. All licensed staff were in-serviced on wound care policy re standard precautions, glove use, and proper sanitizing of scissors by the DNS/ designee on 6/12/12. 2. All licensed staff to complete skill check for Dressing Change, Glove Use completed by DNS/ Designee by 6/24/12. 3. 100% audit of all residents PPD/TB test completion by IDT team by 6/24/12 any residents identified to not be current will have PPD / TB test administered. 4. PPD/TB tests will be tracked in a calendar format at each nursing station. The calendar will be taken to daily stand up meeting to ensure PPD / TB tests are administered timely. D. **HOW MONITORED**: 1. To ensure compliance, the DNS/ | |

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| | Interview on 5/21/12 at 1:30 p.m., with the Corporate Nurse indicated that the one step PPD/TB test was administered on 6/17/11 and the second step PPD/TB test was not given.<br><br>A.2. Resident #47's record was reviewed on 5/24/12 at 8:25 a.m. The record indicated Resident #47 was admitted with diagnoses that included, but were not limited to, asthma, stage IV (4) ovarian cancer and hypothyroidism.<br><br>Admission to the facility was on 4/11/12. The resident received the first step PPD/TB test on 4/13/12 and the second step on 4/27/12, with both tests reading 0.0 mm.<br><br>Interview on 5/24/23 at 9:30 a.m., with the DNS, indicated that the PPD/TB test was given two days late.<br><br>A policy titled, "Resident Screening-Tuberculosis (TB)" with a review date of 12/2011, was provided by the corporate nurse on 5/24/12 at 8:51 a.m. The policy indicated "...TST(tuberculin skin testing) procedure consist of two step procedure-initial injection followed by a second injection 1-3 weeks later...Resident-TB screening, admission two-step-Administer on day of | | Designee is responsible for the completion of the Resident Mantoux, and Infection Control Review CQI tools weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 6/24/12.** | |

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| | admission, per MD order, if resident has not had a documented negative Mantoux (PPD) during the preceding 12 months."<br>B1. RN #1 was observed providing a dressing change to a leg wound for Resident #40 on 5/24/12 at 2:15 p.m.. Wearing gloves, RN #1 used scissors to cut off the soiled dressing from the wound. During interview at this time, the resident indicated the wound began as cellulitis (swelling, weeping) to her lower legs. She indicated she developed a boil on the right lower leg as a result of the cellulitis. She indicated the boil was lanced (cut open) by a doctor, and she was placed on an antibiotic. The soiled dressing was observed to have an area 5 cm (centimeters) in circumference (a circle) of green, thick drainage. As the old dressing was removed, the wound began to bleed, and blood was dripping on the floor. RN #1 cleansed the draining wound. Without changing gloves/washing hands, and without sanitizing the scissors previously used to cut away the soiled dressing, RN #1 prepared the new dressing, cutting the gauze with the scissors, and applied the dressing to the wound.<br><br>In interview with the Director of Nursing Services on 5/25/12 at 8:06 a.m., she indicated the facility did not have a policy for scissor and glove use during | | | |

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| | wound care. Review of the policies provided indicated a policy on non-sterile gloving technique and one for infection control - universal precautions which did not indicate when to change gloves during a dressing change. The policy indicated how to change gloves and when gloves were necessary, and there was no mention regarding cleaning scissors.<br><br>On 5/31/12 at 4:30 p.m., review of the website: http://woundconsultant.com/files/Non_sterile_dressing_change_Procedure.pdf indicated, "Non-sterile Dressing Change ...6. Prepare/open dressing items on table. If dressings need to be cut to size, use clean or sterile scissors...9. Remove soiled dressing, place it in trash bag...10. Remove gloves, wash hands, apply new gloves...12. Clean wound with normal saline or prescribed cleanser...14. Remove gloves, wash hands, apply new gloves...19. Apply wound dressing. Wound dressing should cover entire wound...."<br><br>During interview on 5/24/12 at 2:30 p.m., RN #1 indicated she "will clean the scissors with alcohol." She indicated she saw no problem in the way she did the dressing change. She indicated, "That's the way I always do it." | | | |

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| | 3.1-18(b)(2)<br>3.1-18(e)<br>3.1-18(f)<br>3.1-18(l) | | | |

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| F0514 SS=D | 483.75(l)(1)<br>RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented in that fall risk assessments were inaccurate. This affected 1 of 14 residents in a sample of 15 reviewed for complete and accurate records. (Resident #29)<br><br>Findings included:<br><br>Resident #29's record was reviewed on 5/21/12 at 12:32 p.m. The record indicated Resident #29 was admitted with diagnoses that included, but were not limited to, dementia, high blood pressure, decreased hearing acuity, depression, and macular degeneration (progressive eye disease that leads to blindness).<br><br>Physician's recapitulation orders dated | F0514 | **F-514 Resident Records-complete/ accurate/ accessible**<br>A. **ACTIONS TAKEN**: 1. Resident #29's fall risk assessment reviewed and updated as needed. B. **OTHERS IDENTIFIED**: 1. All other residents have the potential to be affected by the alleged deficient practice. 2. All licensed staff were in-serviced on the completion of the fall risk assessment on 6/12/12. 3. 100% audit of all residents fall risk assessment to be reviewed to ensure accuracy by IDT team by 6/24/12. C. **MEASURES TAKEN**: 1. All licensed staff were in-serviced on the completion of the fall risk assessment by DNS/ Designee on 6/12/12. 2. 100% audit of all residents fall risk assessment to be reviewed to ensure accuracy by IDT team by 6/24/12. 3. The IDT will review fall risk | 06/24/2012 |

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| | 5/01/12 through 5/31/12, indicated Resident #29 had orders for Cerovite liquid, 30 milliliters every day, for macular degeneration, with a start date of 1/9/12, and Zoloft 50 milligrams (mg) every day for depression, with a start date of 1/15/12.<br><br>An annual Minimum Data Set Resident assessment, dated 4/15/12, indicated Resident #29 had highly impaired vision, did not wear glasses, was severely impaired - decisions poor; cues/supervision required in cognitive skills for daily decision making, had 3 falls, 2 with no injury and 1 with a non-major injury, and received an antidepressant medication.<br><br>A fall circumstance report, dated 11/11/11 at 5:30 a.m., indicated Resident #29 fell; while walking with the activities director, his own feet became tangled and he was lowered to the floor by the activities director, and he had no injuries.<br><br>A fall circumstance report, dated 1/10/12 at 5:30 a.m., indicated this resident fell; he rolled out of bed and was found lying beside his bed, and he had no injuries.<br><br>A fall risk assessment, dated 1/20/12, incorrectly indicated the resident did not have a fall in the past 3 months, did not | | assessments upon new admissions, readmission, quarterly, annually and with a significant change in condition. D. **HOW MONITORED**: 1. To ensure compliance, the DNS/ Designee is responsible for the completion of the Fall Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. E. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 6/24/12.** | |

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| | receive a psychotropic medication, and did not have impaired vision.<br><br>A fall risk assessment, dated 4/14/12, incorrectly indicated the resident did not receive a psychotropic medication and did not have impaired vision.<br><br>A policy and procedure for "Documentation Guidelines" was provided by the Director of Nursing on 5/24/12 at 8:30 a.m. The policy indicated, but was not limited to, "Purpose: To accurately document in an organized manner all information related to the resident in the medical record...Supplemental assessments to be completed quarterly, with significant changes, and annually...Fall risk assessment...."<br><br>During an interview on 5/25/12 at 12:58 p.m., the Director of Nursing indicated the fall risk assessments were not correctly coded.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |

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